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ABSTRACT

Refugees, like most other migrants, are at increased risk for various forms of psychopathology. This paper documents the relationship between refugee migration and psychopathology by reviewing pertinent epidemiological, clinical, and survey studies from the refugee literature. The picture that emerges shows consistently increased levels of serious psychopathology (both psychotic and non-psychotic) and high symptom levels across widely different refugee groups. A number of symptoms, syndromes, and disorders that occur with greater frequency among refugees are discussed and summarized. These include depressive syndromes or affective disorders, paranoid syndromes, schizophrenic disorders or brief reactive psychoses, organic brain syndromes such as mental retardation and learning disorders, somatic or psychophysiological disorders, anxiety and post-traumatic stress disorders, substance abuse, antisocial personality or conduct disorder, and other conditions, including "culture bound" disorders. References are included. (Author/TE)

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Psychopathology in Refugees

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Abstract

Refugees, as most migrants, are at an increased risk for various forms of psychopathology. This paper documents the relationship between refugee migration and psychopathology by reviewing relevant epidemiological, clinical, and survey studies from the refugee literature. The picture that emerges shows consistently increased levels of serious psychopathology (both psychotic and non-psychotic) and high symptom levels across widely different refugee groups. A number of symptoms, syndromes, and disorders occur with greater frequency among refugees; these are discussed and summarized. Knowledge about these consistencies in the clinical manifestations of psychopathology among refugees will aid in better planning and service delivery for both the existing refugee groups and future ones.

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Migration, Psychopathology, and Refugee Status

Support for the notion that refugees are a psychologically/ psychiatrically at-risk population can be found in the extensive body of literature on the relationship between migration and psychopathology. Most migrant populations studied in different parts of the world show increased rates of psychopathology (Hemsi, 1967; Malzberg, 1962; Mezey, 1960a; Odegaard, 1932; Rwegellera, 1977; Westermeyer, 1986a). Moreover, the observation of an association between migration and psychopathology is not of recent origin. Odegaard (1932), a pioneer in the area of psychiatric epidemiology, found clinical reports dating back to 1850 which described an increased incidence of "insanity" among foreigners immigrating into the United States. Many of the early studies reviewed by Odegaard reflected a primarily political interest in either proving or disproving the prevalence of mental illness among the foreign immigrant groups, particularly those from ethnic backgrounds which were perceived as less desirable. Serious methodological problems plagued these early studies; many of them, for example, did not use a statistical correction for the different age distributions of the immigrant and native born groups compared, thus arriving at artifactually higher rates of psychiatric illness in the immigrant groups (Odegaard, 1932).

In more recent times, controlled studies have continued to show increased rates of psychopathology even among voluntary migrants moving within their own country (Lazarus, Locke, & Thomas, 1963; Malzberg, 1967; Malzberg & Lee, 1956). Thus it appears that the relationship between migration and psychopathology is both real and stable. It is important to

note, however, that the increased rates of psychopathology observed among migrants (and immigrants) have not been uniform over all ethnic groups nor have they been uniform over all diagnoses (Bagley & Binitie, 1970; Cochrane, 1977; Hemsi, 1967; Rwegellera, 1977; Malzberg, 1962; Odegaard, 1932; Westermeyer, 1986a). Factors such as the circumstances under which the migration took place, the immigration (and emigration) policies of the time, the presence of coexisting disorders such as alcoholism which may mask other diagnostic entities, the diagnostic biases of clinicians, and the availability of treatment for a particular condition, may have all played a role in the variable rates noted throughout the literature (Odegaard, 1932; Rosenthal, Goldberg, Jacobsen, Wender, Kety Schulsinger, & Eldred, 1974; Westermeyer, 1986a). Similar factors may also apply to the specific case of refugees.

It is important to differentiate between immigrants and refugees on both practical and theoretical grounds. Immigrant groups have only occasionally comprised all segments of a whole population with respect to characteristics such as age, sex, and social class (Bernard, 1976); as a general rule, immigrants have been more representative of the disadvantaged classes of a particular population, mostly young and male. Refugees, on the other hand, have generally been represented by all class segments of a society, age groups, and both sexes; many refugee migrations have involved whole populations (Bernard, 1976).

The migration experience of refugees can be differentiated from that of immigrants on the basis of free-choice (Eitinger, 1981); while immigrants have a variety of possibilities with regards to their motivation for migrating, refugees perceive no choice but to leave their homeland. Refugees have also

been characterized as people who are "pushed out" of their homeland, usually by oppressive forces or fear of persecution, while immigrants are "pulled away," generally by attractive forces (Kunz, 1973).

In addition to their involuntary nature, refugee migrations are characterized by other specific and unique features which distinguish them from other migrations. These may include threat to life or freedom, traumatic flight experiences, death of family or friends, torture and imprisonment, concentration and/or refugee camp experiences, prolonged exposure to stress, uncertainty and lack of control over relocation, loss of status or social role, inability to return to homeland, etc. In fact, the refugee experience in itself can be viewed as a unique experience which produces predictable, identifiable and often identical patterns of behavior and sets of causalities across different refugee groups (David, 1969; Kunz, 1973; Stein, 1986; Williams, 1985).

Given these various characteristics which distinguish refugees from the more general category of immigrants, it would be reasonable to expect an equally strong, if not stronger, relationship between refugee migration and psychopathology. One would also expect to find some common trends in the manifestation of psychopathology across refugee groups. This paper will attempt to document the relationship between refugee migration and psychopathology by reviewing the findings of relevant epidemiological studies, clinical studies and survey reports. It will describe chronological and demographic factors affecting the development of psychopathology in refugees. In addition, it will list and discuss specific risk factors that have been identified in different refugee migrations. Finally, the last section of

this paper will summarize diagnostic and clinical information on a number of psychiatric disorders which can be commonly found in refugee groups.

Studies on Refugee Psychopathology

Psychopathology in refugees has been studied primarily in clinical settings with already identified patient groups. Within this context, either epidemiological studies comparing the illness rates of refugees to those of non-refugee populations or descriptive clinical studies and reports have been used to document the nature and extent of the psychiatric difficulties manifested by various refugee groups. A few studies have also collected data on psychopathology in refugees outside of clinical settings usually within the context of population surveys and primarily through the use of questionnaires or self-rating scales. As we shall see, these three broadly different lines of inquiry provide complementary information about the symptoms and disorders that affect refugees.

Epidemiological Studies

Starting with the various groups of refugees and displaced persons from World War II and up to the more recent groups of refugees resulting from the 1975 South East Asian refugee crisis, a considerable number of studies have been devoted to documenting the incidence of mental illness in refugees vis-à-vis that of the host population.

Pfister-Ammende (1955) studied the entire population of mentally ill refugees in Switzerland during World War II within the context of a comprehensive psychiatric program offering mental health services to all refugee camps in that country. This study reported on all forms of mental disorder (and not only on those requiring hospitalization) thus providing a

comprehensive view of a fairly unselected group of World War II refugees prior to their resettlement. The refugees were found to show about "five times as much serious mental breakdown as the settled population of their country of asylum or return." The rate of suicide among the refugees was also approximately five times higher than that of the Swiss population (this latter rate was already considered quite high in comparison to that of other countries). Less serious disturbances requiring only outpatient treatment were also greatly increased; among these "traumatic neuroses" and "reactive depressions" were almost twice as high in the refugees as in the Swiss population. The mentally ill refugees required on the average twice as long (or approximately one year longer) to resettle out of the camps (Pfister-Ammende, 1955).

Murphy (1955) was the first to report high rates of serious psychopathology among World War II refugees following resettlement in England. This particular group of refugees had been originally selected for higher overall health but were brought to England under relatively unattractive resettlement conditions. Murphy found markedly high rates of first admissions to psychiatric hospitals for refugees of both sexes; these rates remained significantly higher than those of the British population even after controlling for differences in age, sex , marital state, and severity of symptoms leading to hospitalization. Schizophrenic illnesses accounted for most of the elevation in hospitalization rates. The rate of suicide in the refugee population was also alarmingly high. Female refugees showed a "massive increase of depressive states" many of which required long hospital stays.

The rates of mental illness for the different national subgroups studied by Murphy (1955) showed a gradation according to the degree of persecution and trauma experienced during the war. Social isolation prior to resettlement showed a similar gradation to persecution. Later inquiry on the mental health and social adjustment of the various refugee communities by way of questionnaire data revealed that the lowest rates of mental hospitalizations occurred in communities where the refugees were mixing with the local population. The rates were also lower where the local population had a friendly, rather than an indifferent or unfriendly, attitude towards the newcomers. However, where the local population was definitely unfriendly to the refugees and mixing did not occur, and especially if the refugee group was small, the rates of mental illness were quite high (Murphy, 1955).

Eastern European refugees were studied again by Hitch and Rack (1980) some twenty-five years after their arrival in England. These investigators examined the records of all first admissions to psychiatric hospitals over a three-year period and found that the foreign-born, of whom Polish and Ukrainian refugees made up about half, had annual rates that were significantly higher than those established for the native-born population. Review of hospital case notes revealed that paranoia as a primary diagnosis was found far more frequently in the refugee groups than in the native-born patients. Between the two refugee groups, the Polish female refugees had the highest rates of hospitalization. The women in this group were described as isolated from the host population by noticeable language difficulties while also lacking connections and sources of support within their own ethnic group. Thus, the authors suggested that

these two factors resulted in a marginal identity which provided inadequate protection against the normal crises and losses of later life when protective immediate relationships begin to decline (Hitch & Rack , 1980).

The epidemiology of psychiatric illness in World War II refugees was also studied in great detail by Eitinger (1959 & 1960) in Norway. This particular group of refugees was described as a special "hard core" or "minus" selection composed of disabled or physically ill people who were taken in by Norway on humanitarian grounds after being passed over by other countries (Eitinger, 1959). A survey of first admissions to public psychiatric facilities during the ten-year period between 1945 and 1955 revealed that the incidence of psychosis in these refugees was five times higher than in the Norwegian population even after correcting for age and sex differences. Intensive case studies showed a preponderance of short-term reactive psychoses with relatively good prognoses among the refugees; on the other hand, schizophrenic illnesses were more common in the Norwegian population. Over 40% of the reactive psychoses occurred during the first year after arrival in Norway and about 65% during the course of the first three years. Among the reactive psychoses, paranoid conditions had the highest frequency but confusional states were also frequent. Problems of linguistic and social isolation along with feelings of insecurity towards the local population were retrospectively identified as "reasonable causes" for the high incidence of psychoses in this refugee population (Eitinger, 1959).

Eitinger and Grunfeld (1965) replicated and extended these results in a second investigation covering the eight-year period between 1956 and 1963 which included the "old" group of refugees remaining in Norway since the war and a "new" group of Hungarian refugees arriving in 1957. In their

second investigation, the "old" refugees showed a distribution of first time hospitalization for schizophrenia to reactive psychoses which resembled that of the settled Norwegian population; the "new" refugees showed again a preponderance of reactive psychoses over schizophrenic illnesses. This finding was consistent with earlier statistical findings among migrants in the United States suggesting that with time the migrant population starts to resemble the characteristics of the indigenous population (Marlzberg and Lee, 1956).

Using methodology similar to Eitinger's, Krupinski and Stoller (1965) surveyed first hospital admission rates for a sample of Eastern European refugees resettling in Australia before 1955. They found that the age standardized incidence of schizophrenia in eastern European refugees was five times greater than in the Australian-born and British and twice as high as that of Southern and Western European immigrants. This trend towards greater serious psychopathology in Eastern European refugees resettling in Australia persisted over the years 1961-1968 when they were studied again (Krupinski, Stoller, & Wallace, 1973).

In their second investigation Krupinski et al. (1973) intensively interviewed a refugee patient sample as well as a non-patient refugee sample gathered from the community to determine psychiatric morbidity, severity of war experiences, and a variety of other pre- and post-migratory factors. They found that Jewish refugees followed by a second group of Polish, Russian, and Ukranian refugees had suffered the most severe war experiences. In both of these two groups the rates of psychiatric illness were found to be proportionate to the severity of war experiences, thus replicating the earlier findings of Murphy (1955) in England; in general,

those refugees who suffered more severe persecution experiences showed a greater number of psychiatric symptoms. Interestingly, however, the Jewish refugees showed the lowest rates of schizophrenia (although this was still several times higher than the rate of the Australian population), a finding attributed to the possible effects of genocidal selection during the war followed by further positive selection through psychiatric screening at the time of migration. A third refugee group identified by these investigators included Baltic, Czech, Hungarian and Yugoslavian refugees; this latter group of refugees had suffered the least severe war experiences. In this third group, the highest rates of psychiatric dysfunction, including schizophrenia, depressive states and alcoholism, were noted among professionals and semi-professionals and were attributed to the stresses of migration and the loss of social status in the new environment.

Paranoid schizophrenia was related to severity of war experiences across all three refugee groups; refugees who were imprisoned or went through concentration camp experiences appeared to be at higher risk for this disorder. In addition, depressive neurosis (dysthymic disorder in our current diagnostic terminology) was also more common in former prisoners and concentration camp survivors, particularly among the Jewish refugees, both in the patient and control groups (Krupinski et al., 1973).

This latter finding of the Krupinski et al. (1973) study was consistent with that of several other previous clinical investigations documenting chronic symptoms of psychological dysfunction among World War II concentration camp survivors. The "concentration camp" or KZ syndrome (after the German term *konzentrationslager*), as this array of symptoms came to be known, was reported to include sleep disturbances, recurrent

nightmares, chronic feelings of anxiety and depression, impaired memory and concentration, fatigue and lack of energy, and pervasive feelings of guilt (Becker, 1963; Chodoff, 1963; Eitinger, 1961; Klein, Zellermayer, & Shanan, 1963; Krystal, 1968; Mattusek, 1975; Ostwald & Bittner, 1968; Thygesen, Hermann, & Willanger, 1970). Given the consistency of these previous findings, it is not surprising that present day refugees, such as the Cambodian refugees who have gone through severe war, imprisonment, and concentration camp experiences, are currently presenting with similar symptomatology which we now label post-traumatic stress disorder (Kinzie, Fredrickson, Rath, Fleck, & Karls, 1984; Kinzie, Sack, Angell, Manson, & Rath, 1986; Mollica, 1987).

A population survey designed to determine the prevalence of mental disorder in a North India community documented high rates of illness among a group of refugees resulting from the partition of India in 1947 (Dube, 1968). This study is altogether different from the ones previously summarized in that it involved a door-to-door survey of all inhabitants in the area (29,468 population) to identify possible cases who were then examined psychiatrically. The Punjabi refugees, members of a warrior caste who had gone through particularly traumatic experiences during their migration, were noted for their high rates of mental disorder. In contrast, another group of refugees resettling in the area, the Sindhis, who had migrated peacefully and settled readily in business occupations, had rates that closely resembled those of the non-refugee population (Dube, 1968).

Finally, the epidemiology of psychiatric illness among refugees has been studied most recently among the South East Asian refugees resettling in the United States. The two studies that have been conducted thus far are

generally of a much more limited scale than the ones just reviewed. This type of epidemiological research becomes very difficult in the United States where there is little uniformity in the availability of mental health care for refugees or central case registries to document rates of hospitalization.

In an early epidemiological study of Vietnamese refugees resettling in Baton Rouge, Louisiana, Vignes and Hall (1979) reported a very low rate of psychiatric illness (11 cases in a population of 488) over the course of one year; they concluded that the rate of psychiatric disorder among this group of refugees was no higher than that of the United States population at large. Cases were identified by consulting the records of local psychiatric facilities; however, there was no mention as to the accessibility of these facilities to the refugees or the possibility of underutilization of traditional mental health care by the refugee population. It is of interest to note that most of the cases found involved psychoses (9 out of 11 cases, or 82%) which suggests that a number of less severely disturbed (and disturbing) cases may have gone untreated and thus undetected.

In contrast, a representative sample of all Hmong refugees living in Minnesota in 1977 showed a very high (18%) incidence rate of psychiatric disorder (both psychotic and non-psychotic) over a one year period (Westermeyer, Vang, & Neider, 1983a). Of note is that almost all the cases identified in this population received diagnosis of major depression according to DSM-III criteria. An interesting difference between the Hmong subjects in this study and the Vietnamese people studied by Vignes and Hall (1979), was that the latter had a much lower rate of welfare dependency and presumably, a higher rate of employment (Westermeyer, Vang, & Lyfong, 1983).

The studies reviewed in this section document almost without exception increased rates of serious psychopathology among different refugee groups studied by different investigators under widely different circumstances. The magnitude of the increase remains difficult to ascertain, however, as it appears to vary somewhat according to the refugee group, the specific type of psychopathology, and the methodology used. Crude rates of illness need to be corrected for age and sex differences at the very least; comparisons between different ethnic groups remain inadequate unless attention is also paid to additional factors such as level of education, marital status, and occupational background. As a general rule, however, refugee groups continue to show appreciably higher illness rates even after correction for at least some of these factors; this suggests that factors pertaining to the refugee experience itself, and not just inadequate methodology, are responsible for the observed increased rates. These factors will be discussed in detail in a later section of this paper.

Clinical Studies/Reports

A considerable number of studies have been devoted to describing clinical aspects of the emotional difficulties, symptoms, and disorders which bring refugees into psychiatric treatment. These studies are summarized here in detail to illustrate the commonalities that can be found throughout widely different refugee groups.

Tyhurst (1951) described the clinical features of psychiatric illness among displaced persons from World War II in Canada based on her observations of both patients and non-patients gathered from the community. She described two characteristic periods in which both groups

developed noticeable emotional reactions. The initial period said to last about two months after arrival was characterized by subjective feelings of well-being (and even mild euphoria) and a tendency to increased activity directed towards taking care of immediate needs. The second period termed the "period of psychological arrival" involved a growing awareness on the individual's part of the difficulties faced in the new environment followed in many cases by rejection of both present and future and marked idealization of the past. It was during this second period that psychiatric difficulties usually became obvious.

Interestingly, most of the patients in Tyhurst's (1951) study were referred for difficulties in adjustment at work or for somatic complaints for which no organic cause could be found even after numerous medical examinations. Almost half of the patients studied were diagnosed as having anxiety or depressive states. Only ten patients in this sample presented with psychotic processess and all of these showed prominent paranoid features. Tyhurst observed that the clinical presentation of many patients changed on an almost day-to day basis. However, she distinguished three main trends in the patients' symptomatology and in the reactions of non-patients: 1) suspiciousness and paranoid trends; 2) anxiety and depression; and 3) somatic complaints. Anxious and depressive feelings could be ascertained in all patients, but these feelings were not readily admitted despite the presence of obvious objective signs. None of the patients reported having had such symptoms under the direct stresses of the war. The somatic complaints showed a typical pattern in both patients and non-patients; initially these consisted of fatigue, muscular or joint pain and disturbances of sleep and appetite; they were then followed by symptoms of pain which

usually developed in various systems and tended to change from one system to another. The somatic complaints of non-patients were transitory in nature while those of patients assumed a more chronic course. In addition, all patients were noted for having recurrent dreams which were in the majority of cases unpleasant and anxiety-laden. The content of the dreams was usually about being attacked ("many sexually"), persecuted, imprisoned, etc. (Tyhurst, 1951).

The Hungarian revolutionary uprising of 1956 created a massive and rather sudden influx of new refugees in Europe. Large unscreened groups of these refugees were accepted by both England and Canada where they were studied in detail by several investigators. In contrast to the refugees and displaced persons from World War II who had usually come from diverse cultural backgrounds and spent several years living in concentration camps prior to resettlement, the Hungarian refugees represented a homogeneous cultural group which was suddenly immersed into a different environment following a brief but rather violent period of complete social upheaval.

Meszaros (1961) studied a group of these refugees (both patients and non-patients) after their arrival in Canada. Following the initial eight to twelve months after arrival many of these refugees were reported to develop "feelings of insecurity and isolation, states of resentment, unhappiness, temperamental behavior and feelings of guilt and inadequacy." He identified five "psychological reaction-types" which he labeled as follows: over-accepting, actively critical, inhibited, hypo-reactive, and hyper-reactive. While Meszaros did not provide a diagnostic breakdown for these different types, he noted that suicidal preoccupations and attempts,

disorderly conduct , as well as severe psychotic confusional states were common in the group of individuals identified as "hyper-reactive." He also observed numerous complaints of fatigue, restlessness, sleep disturbances and fearful recurrent dreams which were virtually identical to Tyhurst's (1951) previous observations among displaced persons.

In another clinical study of Hungarian refugees in Canada, Koranyi, Kerenyi, and Sarwer-Foner (1958) reported a preponderance of anxiety and depressive reactions in a sample of 53 patients studied within the first year of arrival. Nine of the 53 patients received diagnoses of schizophrenia and five of them displayed prominent paranoid features. Ten patients in this series were suicidal; violent suicide attempts were more frequent among male refugees, particularly those who had actively participated in violent acts during the revolution. Coming from a psychoanalytic background, these investigators found marked neurotic conflicts in the early lives of most of their cases. However, they also reported that all of the patients had experienced serious traumatic events including concentration camp and prison experiences, deportation, witnessing the execution of relatives, having their lives endangered repeatedly, etc. (Koranyi et al., 1958). These investigators went on to report on a second group of 178 patients who were referred for treatment between 1958 and 1961. Comparison of the two groups showed that depressive features were prominent in a high proportion of the cases seen within the first year of arrival. In general, they described the symptomatology of the post-revolutionary Hungarian patients studied during the first year of arrival as acute, more flagrant, and showing a greater tendency to violent behavioral expression than that of patients treated in the following four years (Koranyi et al., 1963).

Mezey (1960b) in England reported on a clinical sample of 82 consecutive cases referred for psychiatric treatment within the first two years of their arrival. Half of the patients in this sample had a previous history of psychiatric illness. As in Tyhurst's (1951) study, the most common presenting symptom was physical, either "somatic manifestations of anxiety and depression or a hysterical disorder of function." Abnormal behavior was the next most common presenting symptom and this ranged from aggressive outbursts and suicidal threats to wandering. Mezey (1960b) noted that the initial symptom was rarely expressed in psychological terms such as anxiety and depression and this only ocurred in patients who had previously received psychiatric treatment. Paranoid schizophrenia was the most frequent form of psychoses ascertained in this sample; many of these cases presented with delusions about feeling accused of being Communist spies or alternatively being persecuted by Communist agents. Nearly a third of the sample was diagnosed as having an affective disorder, either a depressive illness or anxiety with depression; these patients also described their illnesses in somatic terms and many blamed the English climate for their symptoms. Almost half of the cases studied presented with behavioral problems, often times antisocial in nature, or with conversion reactions involving both motor and sensory symptoms (Mezey, 1960b).

Paranoid feelings, depressive reactions, and anxiety states have also been described as the most common psychiatric difficulties affecting the first waves of Cuban refugees arriving in the United States between 1960 and 1975 (Rumbaut & Rumbaut, 1976). Azcarate (1973) described the psychiatric symptomatology of these Cuban exiles as an expression of an overwhelming

sense of anxiety, depression and inability to cope with stress. Ruiz (1982) reported that much of the symptomatology found in this refugee group was usually temporary, manifesting itself immediately after arrival, or alternatively, changing with the ups and downs of the political climate in the refugee community; for some cases, there was also a tendency for this symptomatology to reappear at later times, upon relocation, for example. However, the depressive states found in this population took on severe proportions among the elderly in whom isolation and loss of self-esteem commonly resulted in suicidal attempts (Ruiz, 1982). Rubinstein (1976) also observed a preponderance of depressive states which sometimes appeared under a layer of culturally influenced hallucinations and delusions.

Extensive losses, disruption of a previously strong extended family network and exposure to new value systems and financial insecurities were identified as the most common sources of distress for this group of refugees (Ruiz, 1982; Rumbaut & Rumbaut, 1976). These observations are of interest to note since the exile experience of the first waves of Cuban refugees in the United States ocurred under fairly propitious circumstances both in terms of the organized reception accorded to this group and the unusually high degree of educational and occupational preparation of most of the refugees (Portes, 1969).

The initial clinical observations made among the first waves of refugees resulting from the 1975 Indochinese crisis revealed again considerable similarities with those of previous refugee groups. In the group of Vietnamese refugees studied by Rahe and colleagues at Camp Pendleton, for example, psychiatric disorders of psychotic proportions were first observed; with time, however, anxiety and depression, as well as suicide

attempts became the most common problems (Rahe, Looney, Ward, Tung, & Liu, 1978). Mattson & Ky (1978) observing another refugee camp population described a high incidence of psychiatric distress which was being presented in the form of physical symptoms such as headaches, stomach pains and insomnia. Sughandabhirom (1986) reported data gathered at the Khao I Dang refugee camp in Thailand in 1980 indicating that diagnosable psychiatric disorder was rather common among the refugees presenting for outpatient medical services but went largely unrecognized by the general physicians on call. Thus, while one third of all unselected patients examined by a psychiatrist during a week's interval received psychiatric diagnoses, only two percent of those examined by general physicians during the same interval were diagnosed as such.

A pattern of emotional reponses similar to that initially described by Tyhurst (1951) has been subsequently documented over different groups of Southeast Asian refugees resettling in the United States, Canada, Britain, and Australia (Boman & Edwards, 1984; Hawthorne, 1982; Neuwirth & Clark, 1981). The studies that have been conducted with Southeast Asian refugees presenting for psychiatric treatment following resettlement have also yielded similar results to those of previous refugee groups.

An early clinical sample of 50 Southeast Asian refugees described by Kinzie and colleagues in the United States consisted of two separate groups of patients: An initial group of very impaired patients suffering primarily from psychotic illnesses and a second group in which depressive and anxiety disorders were predominant (Kinzie, Tran, Breckenridge, & Bloom, 1980).

Nguyen (1982) reported on a comparable series of 56 Southeast Asian refugees arriving in Canada between 1979 and 1981 (a group also known as

"Boat People"). In this particular series, somatic complaints were the most common presenting problem. As in previous refugee groups (Tyhurst, 1951; Mezey, 1960b), these patients were also subjected to multiple clinical and laboratory investigations before psychological problems were suspected. Most of the patients in Nguyen's study received diagnoses of depression or anxiety (70% of the series). However, anxiety and depressive symptoms were reported in every patient, even those with psychosis; similarly, most patients complained of somatic problems. Four out of nine cases of psychosis could be diagnosed as schizophrenic (three paranoid type); all four patients had had previous psychiatric hospitalizations in Vietnam (Nguyen, 1982).

Westermeyer (1986b) described a clinical series of Indochinese patients (primarily Hmong but also including Lao, Vietnamese, Cambodian, and ethnic Chinese patients) treated at the University of Minnesota from 1977 to 1982. The most common diagnosis in this series of 152 patients was major depression. Many of these patients had received extensive previous medical care including multiple visits to doctors' offices, hospital clinics, emergency rooms, and even hospitalizations for somatic complaints; their depression went unrecognized for weeks and months, even in cases in which it assumed psychotic proportions. Most of the depressed patients were noted to volunteer somatic rather than psychological or interpersonal complaints on initial presentation; however, when asked directly about the latter type of symptoms, they readily reported them (Westermeyer, 1986b).

To summarize, this section has illustrated in detail that the symptoms of emotional distress and psychiatric illness shown by refugees of widely different cultural backgrounds are in most cases virtually indistinguishable. Thus, the clinical observations that have been recently reported for

Southeast Asian refugees differ little from those previously documented among World War II displaced persons or refugees from the 1956 Hungarian uprising. The consistency that is apparent across successive refugee groups recently led Tyhurst (1982) to postulate that symptoms such as suspiciousness and paranoid behaviors, somatic complaints, anxiety and depression are carry-over effects of pre-migratory stressors and can be expected to occur in most refugees. It is unfortunate, however, that these difficulties, which can be serious and disabling at least over the initial period of resettlement, are seldom anticipated and have to be rediscovered with every refugee migration.

Survey/Questionnaire Studies

The two preceding sections summarized information gathered primarily from clinical populations of refugees already identified as having a major psychiatric condition usually of incapacitating proportions. Studies of clinical populations seldom provide information about less disabling symptoms and conditions which can still create considerable suffering and affect adaptation to a new environment. Studies of psychopathological symptoms in non-clinical samples of refugees are important because they reveal difficulties which may not come to the attention of clinicians and otherwise go unnoticed. Knowledge about less disabling but more prevalent difficulties remains very important for planning services and preventive strategies. A number of recent surveys conducted among Southeast Asian refugee populations have relied primarily on the use of questionnaires and self-rating scales to document psychopathology and identify associated risk factors.

An early survey of fourteen Chinese-speaking Vietnamese families living in the Los Angeles area used translated versions of the Zung Self-rating Depression Scale and the Spielberger Anxiety Scale (Yamamoto, Lam, Fung, & Iga, 1977). The findings of this study revealed slight to moderate depression (assessed by mental status examination and confirmed by higher scores on the two self-rating scales) in ten of the fourteen refugee families. Depression in these families appeared to be related to unemployment of the household head.

A second study of Vietnamese refugees used scores on the psychological section of the Cornell Medical Index (CMI) to index psychopathology at two different points in time, in the first year after migration and a year later (Lin, Tazuma, & Masuda, 1979). Unfortunately, only one-third of the subjects were studied at both points in time which raises some questions about how to interpret the findings of this study . The mean CMI scores obtained by these Vietnamese refugees in both phases of the study were several times higher than the normative scores of American and British populations. Using conventional cutoff scores, fifty percent of the refugees could be regarded as having emotional difficulties at both points in time. The CMI profiles of these refugees remained very similar over time with the exception of a reduction in reported feelings of inadequacy and a significant increase in reported anger and hostility in the second year. Higher CMI scores in the second year were found in the following groups: 1) younger and older men as well as in reproductive-age women; 2) married refugees; 3) the widowed or divorced female heads of household; and 4) refugees receiving public assistance.

Westermeyer and colleagues studied a representative sample of all Hmong refugees living in Minnesota in 1977 using translated versions of the 90-item Symptom Checklist (SCL-90) and the Zung Scale for Depression. This investigation differs from the previous one by Lin et al. (1979) in that the same subjects were studied at two points in time. The initial study was carried out at 1.5 years post-migration and the follow up study two years later (Westermeyer, Vang, & Neider, 1983b; Westermeyer, Neider, & Vang, 1984). At 1.5 years post-migration the Hmong refugees rated themselves as experiencing very high levels of depression, anxiety, hostility, phobic fears, paranoid ideation, obsessive compulsive symptoms and feelings of inadequacy. In the initial study, employment was associated with depression, anxiety and obsessive compulsive symptoms; this association led the authors to hypothesize that coming into contact with the realities of their low class status and limited opportunities may have created more emotional distress for these refugees. In addition, factors such as older age, self-reported medical problems, loss of avocational and social roles, and infrequent contact with sponsors were also associated with increased symptom level on the self-rating scales (Westermeyer et al., 1983b).

Two years later the refugees showed considerable improvement in their scores on both self-rating scales. Depression was the one psychopathological symptom which improved the most. Nonetheless, the mean scores of the Hmong refugees remained high in comparison to those of other non-refugee samples (including those of Asians and Asian-Americans). Strict quantitative comparisons are not possible in situations such as this which involve working with translations and lack of normative data on the population before migration. Nonetheless, it appeared that these Hmong

refugees were still showing sustained high rates of depression 3.5 years after migration (Westermeyer et al., 1984).

The survey data reviewed here show that high levels of psychopathological symptoms are also found in refugee groups who do not seek psychiatric treatment. The high initial symptom levels that are documented with this methodology tend to decrease gradually with time although this may be a rather slow process affected by a number of factors. There appears to be a certain degree of variability in the factors associated with increased symptomatology in different refugee groups and at different times following migration. It is hoped that future research on refugee psychopathology will continue to refine the methodology used in these studies so that we can obtain a more systematic longitudinal view of the complex factors which affect refugee mental health and the development of psychopathology at different stages after migration.

Factors Contributing to Increased Psychopathology in Refugees

The highest rates of psychiatric illness in refugees occur during the first year after migration (Westermeyer, 1986a; Williams & Westermeyer, 1983). This is consistent with what occurs in the general case of migrants and highlights the importance of planning for appropriate mental health services during this crucial time period. However, as already indicated by the two survey reports reviewed, high symptom levels can last beyond this initial period (Lin et al., 1979; Westermeyer et al., 1984). Increased rates of certain psychiatric disorders may also manifest themselves a great many years after migration particularly under conditions of sociocultural isolation (Hitch & Rack, 1980; Westermeyer, 1986a).

Incidence rates in refugees are also likely to vary according to sex as observed by Hitch & Rack (1980) in their study of Polish and Ukranian refugees in Britain. Their findings were consistent with those of Krupinski (1967) in Australia who observed a difference between the incidence of schizophrenia in male and female immigrants according to length of stay in the country; the incidence in males was highest one to two years after arrival; in contrast, the highest incidence in females occurred seven to fifteen years after migration. This difference was attributed in part to the fact that men experienced increased levels of stress early on while trying to learn the language and hold a job. Women, on the other hand, remained protected from these early pressures within their families but experienced stress later on as they became the only un-assimilated person in the family (Krupinski, 1967). Westermeyer (1986a) has made similar observations among Hmong refugee women whose level of acculturation (and adjustment) appeared to be delayed as compared to that of the men.

In addition to these chronological and demographic factors, there are a number of more specific factors that appear to mediate the relationship between refugee experience and psychopathology. Significant individual and group differences in these mediating factors can be identified in the literature, not only between refugee groups of different ethnic backgrounds but also among those of similar backgrounds, and even within the same refugee group (Ben Porath, 1987). While much is still unknown about how these factors impact the development of psychopathology in refugees, the available evidence attests to their relevance. Following is a listing of these factors along with a brief discussion of the existing supporting empirical evidence.

Sociocultural Distance: It has been suggested that a greater difference between the culture-of-origin and the host culture results in higher rates of psychiatric dysfunction. While this factor has not been studied systematically among refugees, it is conceivable that refugees from rural and tribal backgrounds may have more difficulties adapting to the primarily urban American lifestyle (Lin, 1986). Support for the "culture shock" phenomenon comes primarily from the literature on migration and has been somewhat mixed (Westermeyer, 1986a). Among Cuban refugees in the United States, Rumbaut & Rumbaut (1976) have also cited the problem of "future shock," referring to the accelerated rate of modernization refugees face even when cultural backgrounds are not widely discrepant with that of the host culture. In a recent study of the Hmong, refugees espousing animist religious beliefs who had been sponsored by fundamentalist Christian clergy showed a high rate of psychiatric disorder (Westermeyer et al., 1983c), suggesting that in their particular case cultural distance may have operated as a pathogenic factor.

Language, education, and occupational skills: Difficulties with verbal communication have an adverse impact on the mental health of refugees, particularly when coupled with social isolation. This was first described in single case reports with respect to paranoid conditions (Edwards, 1956; Kino, 1951) but it has also been documented for larger groups more recently (Eitinger, 1959; Hitch & Rack, 1980). Most recently, Westermeyer, Vang, & Neider (1983c) found that Hmong refugees showed lower symptom levels if they had received English language training prior to migration. With respect to education and occupational skills, higher levels of education and occupational training prior to migration can be assets but they have also

been found to have detrimental effects particularly when similar levels of professional standing cannot be attained in the new environment (Krupinski et al., 1973; Vignes & Hall, 1979). It is almost a universal fact that professional or highly skilled refugees start at lower status occupations than those they had previously attained (Krupinski et al., 1973; Rogg, 1971; Stein, 1979; Stein, 1986; Vignes & Hall, 1979). Some subgroups of refugees may be more affected than others. Older professionals, for example, may be more liable to suffer from the detrimental effects of this factor. For example, Murphy (1955) reported that among Estonian refugees resettling in Sweden half of the younger people were able to regain their former professional status within five years after migration while only one-fifth of the older people with comparable backgrounds were able to do so. In the United States Hmong refugees on public assistance reported more symptoms of hostility than employed refugees (Westermeyer et al., 1983b). However, employed Vietnamese and Hmong refugees have also shown increased levels of depressive symptomatology on standardized self-report measures when compared to the unemployed in each of group (Lin et al., 1979; Westermeyer et al., 1983b).

Personal background: On general grounds one would expect that prior history of psychiatric illness, social maladjustment, or behavioral difficulties would increase the likelihood of subsequent difficulties following migration. However, the existing epidemiological studies on refugees do not indicate the magnitude of enhanced risk to recurrence of prior psychopathology. On the other hand, there is considerable evidence that severe trauma, both physical and psychological, increases the risk for subsequent psychopathology (Dube, 1968; Krupinski et al., 1973; Murphy, 1955). In addition, there appears to be a

gradation between severity of trauma experienced and subsequent rates of psychopathology (Krupinski et al., 1973; Murphy, 1955).

Conditions of migration: These can vary dramatically from one refugee group to another and also within the same refugee group. Traumatic experiences and physical privations before or during the actual migration are not the only factors involved. Governmental policies with regard to immigration can also have a selective effect with respect to the rates of psychopathology manifested after resettlement as well as impact the general health, well-being and attitude of refugees (Eitinger, 1959; Halevi, 1963; Krupinski et al., 1973; Murphy, 1955).

Conditions of resettlement: Existing avenues to assimilation, as in the case of the Sindhi refugees described by Dube (1968), may exert a protective influence. Friendly and receptive attitudes from the host community were associated with lower rates of psychiatric hospitalization in World War II refugees in England (Murphy, 1955). Similarly, having strong links to ethnic social networks was cited as a possible protective influence in the case of the Ukranian refugee women studied by Hitch and Rack (1980) in England. More recently, Berry & Blondel (1982) reported that Vietnamese refugees in Canada who could read, write and speak Chinese showed higher levels of psychological adjustment presumably because they could identify and connect with an already established group of immigrants.

Sponsorship: There are a number of indications which suggest sponsors may play a consequential role in the subsequent mental health of the refugees they help. In a study of the Hmong, both the sponsor's occupation and his/her number of dependents were associated with psychiatric status among the refugees sponsored (Westermeyer et al.,

1983c). Sponsorship by pastors, particularly those with religious beliefs and values highly unlike those of the refugees, was associated with a higher psychiatric morbidity rate, as already indicated. Similarly, the development of subsequent psychiatric illness in the refugees was associated with sponsors who had three or more children of their own; these sponsors had less frequent contact with their refugee charges presumably because of their heavier family commitments (Westermeyer et al., 1983c). Williams and Westermeyer (1983), have described two cases of inappropriate sexual behavior in foster parents of unaccompanied Southeast Asian adolescent refugees referred for psychiatric treatment.

Ethnicity/National origin: The studies reviewed demonstrate that, in general, both psychotic and non-psychotic conditions appear to increase among refugees. With respect to psychotic illnesses (and probably most non-psychotic conditions, as well), there is no evidence to support the notion that the incidence for these conditions is higher in the population of origin (Eitinger, 1959; Mezey, 1960a; Pfister-Ammende, 1955). However, the rates of disorders with a strong behavioral component, such as alcoholism and substance abuse, are likely to show ethnic and national differences (Pfister-Ammende, 1955; Westermeyer, 1986a).

Etiology of Psychopathology in Refugees

The contributory roles of the individual's premorbid adjustment (and his/her innate vulnerability to psychiatric illness) versus those of the psychological and physical stressors that accompany migration have been vigorously contested over the past several decades, particularly with respect to schizophrenia (Eitinger, 1959; Mezey, 1960a; Odegaard, 1932; Rosenthal et

al., 1974; Sauna, 1970). Extending this line of inquiry to the case of involuntary migration, Mezey (1960b) studied the social adaptation of Hungarian refugees in England. He found that refugees who went on to develop affective disorders (primarily depressive and anxious conditions), showed a significant disruption in their social adjustment following migration. Refugees who went on to develop schizophrenia after migration tended to be already "marginally adjusted" people before migration. Thus, Mezey concluded that the stress of migration did not seem to have etiological importance in the causation of schizophrenia but was probably very important in those affective disorders which occur early after migration.

Eitinger (1959) cautioned against an "either-or" formulation noting that, in his studies, the stress of the refugee situation appeared to accelerate the breakdown of schizophrenic processes while also coloring the initial symptomatology, although with time, these initial situationally determined characteristics came to pass, revealing the typical symptomatology and course of the disorder. In Eitinger's own words,

> "The symptoms which are brought about by the situation disappear to give way to typical schizophrenic symptoms, totally independent of refugee existence and its problems: the schizophrenic process which at first was coloured by the pathoplastic tugging of the actual situation, breaks through, takes the lead and dominates the actual situation both with regard to symptomatology and course." (Eitinger, 1959, p. 335)

Our understanding of psychopathology in the past two decades has increasingly included biological endowment as the major determinant of

illnesses such as schizophrenia and bipolar affective illness. On the other hand, the role of environmental factors in determining illness has remained vague and largely unspecified (Heston, 1987). With respect to the question of refugee psychopathology, however, we must keep in mind that the existing epidemiological data are still quite limited. It is unknown to what extent stress may have a "pathoplastic" influence in the more biologically determined psychiatric illnesses as Eitinger (1959) suggested. As Eitinger's own study revealed, and the current literature review further supports, refugees tend to show a preponderance of reactive psychopathological processes characterized by specific symptomatology, thus underscoring the etiological importance of stress in the development of most forms of psychopathology in refugees. Eitinger's maxim of "not either/or but both/and" may still prove useful, however, since in the case of refugees a number of factors may combine to modify the eventual manifestation of psychiatric illness (Eitinger, 1960).

Westermeyer (1986a) has recently emphasized the need to view the increased risk of psychiatric illness in refugees as occurring against a background of genetic, constitutional, family, personality, socioeconomic and cultural factors. These various factors, and their complex inter-relationships, can increase an individual's vulnerability as well as his/her invulnerability to psychiatric disorder. Thus, when evaluating refugees clinically, it remains important to consider both migration and non-migration factors that can add strength and/or liability to each individual's capacity to adjust (Westermeyer, 1986a).

Common Psychiatric Disorders among Refugees

As would be expected in any other human population, refugees show all forms of psychopathology. However, as this review has demonstrated, there are some types of psychopathology which occur more commonly among refugee groups. These disorders will be summarized in this section.

It is important to note that refugees who present to clinical facilities for treatment frequently have associated medical and social problems in addition to a psychiatric disorder. Sometimes these additional problems may be even causative of the psychiatric condition; in other instances, additional problems may have developed as a consequence of the psychiatric condition. Regardless of the relationship, it is not possible (or good practice, for that matter) to ignore these associated problems. Clinicians shoud be particularly alert to physical problems such as war or torture injuries, anemia, hypovitaminosis, parasitosis, and unrecognized chronic health problems such as hypertension and gout. Social problems which require immediate attention and intervention include abuse or assault by family or strangers, and victimization or harassment in general. Other commonly encountered social problems that need to be recognized in treatment planning include unemployment, marital and/or family disruption, and social isolation.

Depressive Syndromes and Affective Disorders

Prolonged, disabling depressive syndromes occur with greatly increased incidence among refugees. These syndromes run the gamut from simple episodes of major depression to those marked by psychotic features and melancholia (Kinzie, Tran, Breckenridge, & Bloom, 1980; Kinzie, Manson, Do, Nguyen, Bui, & Than, 1982; Murphy, 1955; Pfister-Ammende, 1955; Westermeyer, 1986a). Not surprisingly, depression has been identified as the

most frequent mental health problem leading to psychiatric treatment in widely different refugee groups (Mezey, 1960b; Nicassio, 1985; Nguyen, 1982; Rubinstein, 1976; Rumbaut, 1977; Westermeyer, Vang, & Neider, 1983a). Most recently, depression, oftentimes characterized by endogenous symptoms and vegetative signs, has been identified as a major health problem among the Southeast Asian refugees in the United States and Canada (Erickson & Hoang, 1980; Lin, Ihle & Tazuma, 1985; Muecke, 1983).

The importance of recognizing clinical depression among refugees is highlighted by the fact that, if left undetected and untreated, it can be extremely disabling. Even a simple, uncomplicated case of depression can have grave consequences for a refugee faced with the need to learn a new language, adapt to a new society, and seek or maintain a completely new line of work in a foreign environment. Of great importance also is the well-established relationship between suicide and depression. A recent clinical report identified depression as one of the major determinants of suicidal behavior among Southeast Asian refugees (Alley, 1982). Similarly, attempted suicide was the second most common problem leading to psychiatric referral in another sample of Southeast Asian refugees (Nguyen, 1982).

Many refugees, and Southeast Asian refugees in particular, have been noted to present with somatic rather than emotional or psychological complaints. Mollica and Lavelle (1986) have recently reviewed the "somatization controversy" as it relates specifically to depression among Southeast Asian refugees. They point out that the greater incidence of a somatic presentation, even in patients who clearly meet diagnostic criteria for depression, is indicative of an attributional difference; patients actually acknowledge experiencing more purely psychological symptoms of

depression but treat them as secondary in importance to their somatic complaints. Likewise, a tendency to somatize may reflect the patient's conceptualization of what are relevant illness elements; patients who present with somatic complaints may not view psychological problems as warranting medical attention (Mollica & Lavelle, 1986).

Affective conditions other than depression in refugees have been documented with much less frequency. Cases of mania and bipolar illness occur in only a very small percentage of refugees presenting for psychiatric treatment. It is unknown whether these conditions show an actual increased lifetime prevalence among refugees. Nonetheless, it is important to recognize these conditions when they occur because they tend to have a good prognosis if treated appropriately. Recognizing mania and bipolar illness in refugees may be particularly challenging, however. Manic episodes may be difficult to diagnose as such if they present under a layer of delusions and hallucinations. First time manic episodes among young people may be obscured by "acting out" behaviors, antisocial characteristics and drug use.

Misdiagnosis of bipolar illness for schizophrenia has been reported consistently for white majority patients in the United States, particularly when patients present with symptoms such as auditory hallucinations or delusions (Edwards, 1972; Garvey & Tuason, 1980; Keisling, 1981; Taylor & Abrams, 1978). In addition, there is evidence to suggest that bipolar patients from certain minority groups such as blacks and Hispanics may be even more likely to be misdiagnosed as schizophrenic (Jones, Gray, & Parson, 1983; Jones, Gray, & Parson, 1981; Mukherjee, Shukla, Woodle, Rosen, & Olarte, 1983).

Extrapolating from these findings to the general case of refugees who are also members of ethnic and racial minorities, one could expect a similar potential for greater misdiagnosis of not only mania but also psychotic depressions, particularly if affectively ill refugees as a group also tend to be hospitalized in more severe and deteriorated states than white majority patients; the latter situation appears to occur in the case of both blacks and Puerto Rican Hispanics in the United States (Guze, Woodruff & Clayton, 1975; Mukherjee et al., 1983).

Paranoid Syndromes

Persecutory delusions as well as other manifestations of paranoid trends are found with great frequency among refugees. These may range all the way from transient paranoid feelings and attitudes easily attributed to a particular political climate and needing little clinical intervention (Ruiz, 1982) to full-blown psychotic states requiring careful assessment and treatment (Jack, Nicassio, & West, 1984; Lin, Masuda, & Tazuma, 1982). Reactive psychotic states characterized by persecutory delusions and ideas of reference have been consistently reported among refugees and displaced persons (Kino, 1951; Edwards, 1956; Prange, 1959). Prominent paranoid symptoms have also characterized the reactive psychoses as well as the schizophrenic disorders that have been observed among refugees (Eitinger, 1960; Koranyi et al., 1958; Mezey, 1960b; Tyhurst, 1951). In addition, suspiciousness and paranoid trends have been observed in refugee patients with all diagnoses (Tyhurst, 1951). Similar earlier observations had led Pedersen (1949) to state the following: "... it is no mere coincidence that in the treatment of refugees one is almost every where dealing with paranoid reactions . . ." (page 345). This greater frequency of paranoid features in

refugees may contribute to the incorrect diagnosis of schizophrenia in cases of affective and paranoid psychoses. The latter situation, misdiagnosis of paranoid psychoses for schizophrenia, has been reported to occur in the case of African, West Indian, and Asian immigrants in Britain (Carpenter & Brockington, 1980).

Paranoid disorders may remain a risk for refugees many years beyond resettlement, particularly in those refugees who remain isolated because of limited abilities to communicate with the mainstream groups and by lack of social cohesion or support systems within their own ethnic group (Hitch & Rack, 1980). Serious family and community repercussions can result in cases of paranoid disorder. Pathological jealousy and delusions about spouse infidelity are common and can lead to physical abuse and family violence. Divorce and family break up are thus frequent consequences. Suicide and homicide may also occur as complications in a small but significant pecentage of cases.

Westermeyer (1986a) has reported observing several cases of collective or shared paranoid delusional systems among Hmong refugees who have been placed in isolated rural areas; one of these cases involved a suicide attempt by a whole family. While cases of collective delusions are fortunately infrequent, they remain significant because they tend to involve several individuals and carry severe consequences for the group and the community in question (Westermeyer, 1986a).

Schizophrenic Disorders and Brief Reactive Psychoses

Despite the increased incidence of schizophrenic disorders that can be found among refugee groups in comparison to non-refugee populations (Eitinger, 1959; Krupinski et al., 1973; Murphy, 1955), these disorders

actually occur in only a small percentage of refugees. While these disorders comprise only a minority of the mental health problems that afflict refugees, they assume major porportions in other respects (e.g. prolonged course, need for recurrent hospitalizations and ongoing pharmacotherapy, extensive disability and family/community repercussions). Delay of hospitalization for these disorders has been reported in both immigrant and refugee groups (Westermeyer, 1986a). Access to culturally sensitive assessment and treatment may help prevent severe deterioration and reduce the number of poor clinical outcomes that might result otherwise.

Among refugees, brief reactive psychotic processes are more common than schizophrenic disorders (Eitinger, 1959 & 1960; Lin, 1986; Lin et al., 1982). By definition these psychotic conditions are always preceded by a recognizable stressful event to which the patient displays a strong emotional reaction. They are characterized by a florid psychotic presentation which may include incoherence or loosening of associations, delusions and hallucinations, and grossly disorganized or catatonic behavior. They are further characterized by their short duration and an eventual return to premorbid functioning. In addition, there is no evidence of previous psychosis and premorbid functioning is usually good. In refugees these psychotic reactions have been typically characterized by persecutory delusions or by disturbances of conciousness in the form of confusional states (Eitinger, 1960). Thus, two general "types" of reactive psychoses have been identified in refugees: Paranoid reactions and hysterical psychoses (Lin et al., 1982). Social and linguistic isolation appear to be major contributory factors in the development of paranoid reactions (Eitinger, 1960; Edwards, 1956; Kino, 1951; Lin et al., 1982). Linguistic barriers between clinician and patient as

well as lack of knowledge of the patient's culture and background may contribute to misdiagnosis of these reactive conditions (Jack et al., 1984; Lin et al., 1982).

Organic brain syndromes, Mental Retardation, and Learning Disorders

Refugees as a general rule have a greater exposure to head trauma, infectious diseases and malnutrition throughout different stages of the refugee experience. Among refugees who have lived through war experiences, gunshot and explosive injuries to the head may be common. Similarly, traumatic injuries to the head are very frequent among those who have suffered imprisonment or torture experiences. Starvation during the refugee flight is common and can result in varying degrees of nutritional and vitamin deficiencies (Lin, 1986). The cognitive impairment resulting from these various insults to the brain can often lead to severe limitations in the person's ability to adapt to a new environment, even though he/she may have been able to function, albeit marginally, in the country of origin.

There is very little information (either clinical or epidemiological) on mental retardation and learning disorders in refugee populations. However, these conditions are encountered frequently in clinical practice. Williams and Westermeyer (1983) reported on six cases of mental retardation among Southeast Asian adolescents. None of the cases were retarded from birth; "fevers" during childhood were often identified by parents as the onset of intellectual impairment. Westermeyer (1986a) observed the sequelae of malnutrition in several mentally retarded Southeast Asian children. This author has come across several cases of reported trauma to the head sometimes leading to seizures among adolescent "Mariel" Cuban entrants referred because of suspected intellectual impairment. Other refugee

adolescents referred for assessment of possible learning deficits have presented with prominent depressive syndromes or significant symptoms of emotional difficulties while showing fairly intact cognitive abilities.

The process of evaluating for organic involvement and assessing current potential is usually made difficult by lack of adequately translated and normed psychological and neuropsychological tests (Williams & Westermeyer, 1983). However, some general guidelines for the use of psychological tests with refugees as well as a listing of the assessment instruments available for different language groups can be found in a recent paper by Butcher (1986). In addition, Irwin & Madden (1986), have recently described a psychoeducational assessment program for Southeast Asian children and adolescents which offers some preliminary normative data for these populations.

Somatization, Somatoform Disorder, and Psychophysiological Disorders

Refugees of various different backgrounds have been observed to present with a high frequency of somatic symptoms, especially as initial complaints (Eitinger, 1960; Lin, Carter, & Kleinman, 1985; Lin et al., 1982; Mezey, 1960b; Nguyen, 1982; Tyhurst, 1951). A number of reasons have been suggested to explain this greater tendency towards somatization of psychological distress in refugees. Lin (1986) listed the following: The traditional backgrounds of most refugees which discourage direct expression of feelings, culturally-shaped health beliefs which favor psychosoma unity, lack of familiarity with the concepts of mental health and mental health care, and the language barriers which prevent refugees from communicating in a more abstract psychological manner.

An unfortunate consequence of somatization is that, when undetected by inexperienced clinicians, it often leads to unnecessary and costly medical searches; these searches in turn work to emphasize and reinforce the somatic symptoms and delay the indicated psychiatric care while the patient continues to deteriorate. On the other hand, the initial somatic presentation of these patients is usually observed to clear as they start to respond to psychiatric treatment (Westemeyer, 1986a). The presence of frequent medical treatment, including hospital and emergency room visits, should alert practitioners to the possibility of psychiatric disorder (Westermeyer, 1986b)..

While somatic compaints are common, somatization disorder and hypochondriasis are not particularly frequent among refugees. However, these disorders are sometimes incorrectly diagnosed in the presence of a psychotic depression involving somatic delusions. Finally, it is of interest to note that Westermeyer (1986a) has observed high rates of psychologically precipitated physical conditions (psychophysiologic disorders) among Southeast Asian refugees. Examples of these disorders include allergic rhinitis, asthma, eczema, hives, rheumatoid arthralgias, and migraine headaches.

Anxiety Disorders and Post-traumatic Stress Disorder

The high prevalence of anxiety symptoms among refugees has been documented in several clinical studies of various refugee populations (Koranyi et al., 1958; Mezey, 1960b; Nguyen, 1982; Tyhurst, 1951). There is little information in the literature that would suggest an increased frequency of panic and generalized anxiety disorder, or of phobic and obsessive compulsive conditions. Nonetheless, Lin (1986) has suggested that the

general elevation of anxiety symptoms in most refugees may serve as fertile ground for the development of these conditions.

The refugee literature abounds with symptom descriptions which match those of the current diagnostic criteria for post-traumatic stress disorder (Eitinger, 1960; Krupinski et al., 1973; Mezey, 1960; Pedersen, 1949; Tyhurst, 1977). Both the disorder and, perhaps to an even greater extent, the isolated symptoms of this condition (such as sleep disturbance and recurrent recollections or dreams about traumatic events) are very prevalent among refugees. Clinically, these symptoms can also be found in adolescents, as well as in some children.

Krupinski's et al. (1973) findings among World War II refugees in Australia revealed that those refugees with the most severe persecution and war experiences had both a higher frequency and a higher intensity of neurotic symptoms resembling those in the KZ syndrome. Similar clinical symptomatology is now being identified among Cambodian concentration camp survivors (Kinzie et al., 1984; Kinzie et al., 1986; Mollica, 1987). Judging from the extensive literature on Jewish holocaust survivors, it appears that both PTSD symptoms as well as the full disorder can be long-lasting, although they may not always be associated with incapacitation or maladjustment. However, a more serious clinical picture and less favorable outcome may result when PTSD is accompanied by a major depressive disorder, a fairly common occurrence. An additional complication which may arise in PTSD cases involves drug addiction, since individuals frequently try to cope with their symptoms by using alcohol or drugs (Horowitz, 1986).

Substance Abuse

Rates of substance abuse problems among refugees are likely to vary according to cultural background and may also depend on the particular drug in question. Lin (1986) has recently pointed out that the rates of alcoholism among Southeast Asian refugees may no longer be as low as initially believed. In their longitudinal study of a group of Vietnamese refugees, for example, Lin and colleagues found a marked increase in their subjects' reported use of alcohol from year to year (Lin et al., 1982). Westermeyer (1986a) noticed that some refugees may show a drop in sustance abuse upon migration; factors such as financial constraints or unavailability of indigenous substances of abuse are likely to play a role in retarding initial problems. At the same time, replacement of a traditional drug by another one which may be more available in the resettlement country can also occur. This appears to be the case among some Hmong refugees in the United States whose medicinal and recreational use of alcohol has become very similar to their traditional use of opium in Asia (Westemeyer, 1985). However, refugee groups can also introduce their own traditional substance of abuse after resettlement; this also appears to be occurring among some refugees from Laos (Hmong, Lao, and Tai Dam).

In the absence of other therapeutic alternatives, refugees are more likely to turn to drugs and alcohol in their attempts to cope with symptoms such as insomnia, panic attacks, impotence, psychogenic pain, etc. Lin (1986) warned that refugee adolescents run a higher risk of developing substance abuse problems due to their greater exposure to the youth culture in the host society and the weakening of traditional values and ties in their own ethnic group. This has been an increasing area of concern in the Southeast

Asian community. A parallel to this current situation among Southeast Asian refugees can be found among the earlier Cuban refugees in the United States. In the latter group, the younger male refugees, in particular, responded to family disruption and the economic and social pressures of immigration by increased use of illegal drugs (Page, Rio, Sweeny, and McKay, 1985).

Antisocial Personality and Conduct Disorders

In general, these disorders have not been reported to show an increased frequency among refugee groups with the exception of groups which are pre-selected for migration because of an already existing history of behavioral problems or a criminal history. This recently occurred in a small but significant minority of the Cuban entrants from the Mariel boatlift of 1980; it is well-known that many individuals were sent by the Cuban government directly from long-term psychiatric facilities, prisons, and institutions for delinquent minors (Boxer & Garvey, 1985; Szapocznik & Cohen, 1986). One may also note that acting out behaviors and conduct disturbances, oftentimes of a rather violent nature, were described among the Hungarian refugees shortly after their resettlement in England and in Canada (Koranyi et al., 1958; Meszaros, 1961; Mezey, 1960b).

Among Southeast Asian refugees, Williams and Westermeyer (1983) have described cases of behavior problems in adolescents which predated the refugee crisis. In these cases, it appeared that families saw the refugee crisis as an opportunity to solve their problems with disturbed or disturbing adolescents (Williams & Westermeyer, 1983). Both Carlin (1979) and Williams and Westermeyer (1983) noted that some unaccompanied Southeast Asian adolescents had been "street children" whose daily survival depended on their ability to obtain food by stealing, cheating, and tricking

others. Similarly, Tans (1983) and Carter (1983) have described long-standing behavior problems among the Cuban unaccompanied minors who came in the 1980 boatlift, also suggesting a group at high risk for continued difficulties.

Two other high risk groups have been identified. They are the Amerasian children and adolescents who have been frequently living in the streets before coming to this country and the sons in single-parent households usually headed by widowed mothers (Ben-Porath, 1987; Williams, 1987). In the latter case a typical clinical presentation involves a very depressed woman who has been physically abused, and actually terrorized, by her son (or sons), who in turn may be abusing drugs and running into difficulties with the authorities.

Other psychiatric conditions and "culture bound" disorders

Any and all forms of psychopathology can be found among refugees. Some conditions, such as eating disorders, which may have been very rare in the refugees' country of origin, may start to appear in the country of resettlement. Other conditions which have been traditionally expressed in a culture-specific manner may continue to occur as well. Williams and Westermeyer, for example, observed a case of koro, a "culture bound" syndrome involving a somatic delusion, in a young Southeast Asian male refugee; in this particular case, both the young man and his family shared in the delusions that his penis was receding into his abdomen (Westermeyer, 1986a). Similar unusual presentations of psychopathological processes have been described for other immigrant and refugee populations in the United States (Weidman, 1983). While these cases are undoubtedly unusual and fascinating, it would be a mistake to assume that they represent forms of

psychopathology that cannot be diagnosed and treated with our existing diagnostic tools and treatment modalities. This is not to say that knowledge of the traditional illness beliefs and health practices of refugee groups is unimportant, for it is actually this kind of knowledge which enables clinicians to carry out culturally-sensitive assessments and effective treatment interventions (Scott, 1974; Weidman, 1983).

Concluding Comments

This review paper has spanned over forty years of studies and reports documenting various psychiatric outcomes of the refugee experience in widely different refugee groups, throughout different countries and historical circumstances, and through the use of divergent methodologies. The picture that emerges from this literature provides incontrovertible evidence that the refugee experience is detrimental to mental health and does lead to increased rates of psychiatric dysfunction.

Refugees, as any other human population, will present with any and all forms of psychopathology. However, a number of symptoms, syndromes and disorders appear to occur more commonly among refugee groups. Again, there are considerable similarities and consistencies in the clinical manifestations of psychopathology across different refugee groups; these similarities and consistencies outweigh cultural and ethnic differences.

This review also reveals a trend that has been apparent in other recent reviews of related aspects of the refugee mental health literature: A tendency to rediscover certain peculiarities of the refugee experience with each new wave of refugees impacting the mental health care system of the resettlement country (Ben-Porath, 1987; Williams, 1987). With respect to

psychopathology, this rediscovery process takes place in the form of reports and studies which seem to emphasize the unusual nature of the psychiatric difficulties experienced by a particular refugee group when, in fact, such difficulties have usually been described for other previous refugee groups. It is hoped that increased knowledge and awareness of the existing refugee literature will lead both researchers and practitioners to focus their efforts on developing and implementing preventive strategies to ameliorate the detrimental effects of the refugee experience and on devising and evaluating culturally sensitive assessment and treatment approaches for refugees.

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